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Notice of Independent Review Decision

DATE: January 27, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Reconsideration Work Hardening Program (80 hours) 97545, 97546

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
The reviewer is certified by the American Board of Physical Medicine and Rehabilitation with over 20 years of experience.

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a male who injured his back when he was involved in a motor vehicle accident while working on xx/xx/xx.

10/29/14: The claimant was evaluated who complained of low back pain following a work-related motor vehicle accident that occurred on xx/xx/xx. The claimant stated that he was a rear passenger on the passenger's side when the vehicle was struck by another vehicle on the driver's side. He noted continued pain since that time with some numbness and tingling in his left arm starting at the elbow region and going into the fingertips. He denied having any left upper extremity trauma. He was status post 6 out of 10 physical rehabilitation sessions. He stated that he was getting some improvement from the therapy but was still having a difficult time when trying to sleep at night. It was noted that revaluation during physical rehabilitation resulted in recommendation for him to be advanced onto a WHP. He was working with restrictions. He was a current smoker of less than 1 PPD. His medication list included ibuprofen 800 mg and Ultram 50 mg. On exam, the back was noted for no evidence of any deformity, no edema, and no discoloration. There was decreased active range of motion of the thoracic and

lumbar spine region secondary to pain. There was mild tenderness to palpation over the thoracic and lumbar paraspinous muscle tissues. Otherwise, he was neurovascularly intact. Plain films of the C-Spine dated 08/12/14: Impression: No acute radiographic abnormality identified. Plain films of the thoracic spine dated 08/12/14: Impression: No acute bony abnormality identified. IMPRESSION: Mild and lower back myofascial strain. PLAN: UDS ordered. Recommend advancing to WHP upon completion of physical rehab. Form-73 completed. Follow up in 1 month. Ibuprofen 800 mg 1 p.o. t.i.d. #90. Ultram 50 mg 1 p.o. q.i.d. #120.

11/04/14: The claimant underwent a Functional Capacity Evaluation. It was noted that he had been employed with his position as a Traffic Control for 4 months and that during the initial intake patient intake process, he claimed to be working part-time and described his work being “same job with same employer.” It was noted that he explained his job as “same job just with restrictions and making sure people are putting things in the right place.” It was also noted that restrictions had been placed by the treating doctor for his work duties and that Mr. took time off from work from xx/xx/xx to xx/xx/xx. It was noted that since last evaluation (date of last evaluation not noted), he made objective improvements in range of motion, static strength, dynamic lifting, functional specific testing, NIOSH, hand grip, pinch grip, Dallas Pain Questionnaire, and Oswestry Low Back Disability Index, and Neck Disability Index, and notable improvements in his subjective complaints with regards to his injury. It was noted that he demonstrated functional deficits on evaluation that would benefit from additional medical attention, including therapy and/or diagnostic testing. recommended psychological evaluation, referral for injections, and continue with some form of continued active care such as therapeutic exercise, active therapy, or some form of tertiary vocational therapy such as return to work program. He was not felt to meet requirements to do his job safely, effectively, and confidently without restrictions. His required PDL was very heavy, and his current physical performance level was medium.

11/06/14: The claimant was evaluated by a psychology team staff member and, with who stated that he required a comprehensive occupational rehabilitation program for successful return to work and medical case closure. It was noted that he had an agreed upon vocational goal, had a targeted job to return to, and met all accepted criteria for entrance into the comprehensive program.

11/06/14: The claimant was evaluated. His BDI-II results and BAI revealed a score of 10 on the BDI-II, indicating minimal depression, and a score of 26 on the BAI, reflecting severe anxiety. His FABQ showed significant fear avoidance of work (FABQ-W = 36, cut off is 29) as well as significant fear avoidance of physical activity in general (FABQ-PA = 23, cut off is 13). It was felt that he would be an “excellent candidate for the Work Hardening Program since the combination of intensive physical rehabilitation, work stimulation, and didactic group psychotherapy services offered in this program may facilitate resolution of functional deficits and mood disturbances, thus facilitating a safe and successful return to full-duty work.”

11/21/14: UR. RATIONALE: ODG guidelines support a work hardening program when there is evidence of improvement with physical therapy followed by plateau, with evidence of no likely benefit from continuation of this previous treatment. In this case, while the claimant has yet to meet required physical demand level for full duty, there is limited documentation of prior physical therapy visits to indicate a plateau. Furthermore, the claimant did not have an improvement in physical demand level from one functional capacity evaluation to the next. Therefore, the current request is not supported, as there is not a clear plateau with previous services.

12/31/14: UR. RATIONALE: The additional records for the reconsideration process were in the form of the reconsideration letter as noted in the Clinical Summary above. The previous non-certification is supported. The documentation provided for review notes the previous physical therapy has provided benefit to the claimant. The claimant is stated to have had improvement from light-medium to medium physical demand level based upon the Functional Capacity Evaluations that have been performed. There is no evidence that the claimant has plateaued with the services that have been provided and there is no documentation that there is evidence of no likely benefit from continuation of previous treatment. Based upon the medical documentation provided for review and the peer-reviewed, evidence-based guidelines, the reconsideration request for work-hardening program, 80 hours, is not certified.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The previous adverse decisions are upheld. ODG states in evaluating for a work hardening program, "There is evidence of treatment with an adequate trial of active physical rehabilitation with improvement followed by plateau, with evidence of no likely benefit from continuation of this previous treatment. As previously sited, there is no documentation that the claimant plateaued functionally. There for the request for Reconsideration Work Hardening Program (80 hours) 97545, 97546 is not medically necessary.

ODG:

Work conditioning, work hardening	**Criteria for admission to a Work Hardening (WH) Program:** (1) *Prescription:* The program has been recommended by a physician or nurse case manager, and a prescription has been provided. (2) *Screening Documentation:* Approval of the program should include evidence of a screening evaluation. This multidisciplinary examination should include the following components: (a) History including demographic information, date and description of injury, history of previous injury, diagnosis/diagnoses, work status before the injury, work status after the injury, history of treatment for the injury (including medications), history of previous injury, current employability, future employability, and time off work; (b) Review of systems including other non work-related medical conditions; (c) Documentation of musculoskeletal, cardiovascular, vocational, motivational, behavioral, and cognitive status by

	a physician, chiropractor, or physical and/or occupational therapist (and/or assistants); (d) Diagnostic interview with a mental health provider; (e) Determination of safety issues and accommodation at the place of work injury. Screening should include adequate testing to determine if the patient has attitudinal and/or behavioral issues that are appropriately addressed in a multidisciplinary work hardening program. The testing should also be intensive enough to provide evidence that there are no psychosocial or significant pain behaviors that should be addressed in other types of programs, or will likely prevent successful participation and return-to-employment after completion of a work hardening program. Development of the patient's program should reflect this assessment. (3) *Job demands:* A work-related musculoskeletal deficit has been identified with the addition of evidence of physical, functional, behavioral, and/or vocational deficits that preclude ability to safely achieve current job demands. These job demands are generally reported in the medium or higher demand level (i.e., not clerical/sedentary work). There should generally be evidence of a valid mismatch between documented, specific essential job tasks and the patient's ability to perform these required tasks (as limited by the work injury and associated deficits). (4) *Functional capacity evaluations (FCEs):* A valid FCE should be performed, administered and interpreted by a licensed medical professional. The results should indicate consistency with maximal effort, and demonstrate capacities below an employer verified physical demands analysis (PDA). Inconsistencies and/or indication that the patient has performed below maximal effort should be addressed prior to treatment in these programs. (5) *Previous PT:* There is evidence of treatment with an adequate trial of active physical rehabilitation with improvement followed by plateau, with evidence of no likely benefit from continuation of this previous treatment. Passive physical medicine modalities are not indicated for use in any of these approaches. (6) *Rule out surgery:* The patient is not a candidate for whom surgery, injections, or other treatments would clearly be warranted to improve function (including further diagnostic evaluation in anticipation of surgery). (7) *Healing:* Physical and medical recovery sufficient to allow for progressive reactivation and participation for a minimum of 4 hours a day for three to five days a week. (8) *Other contraindications:* There is no evidence of other medical, behavioral, or other comorbid conditions (including those that are non work-related) that prohibits participation in the program or contradicts successful return-to-work upon program completion. (9) *RTW plan:* A specific defined return-to-work goal or job plan has been established, communicated and documented. The ideal situation is that there is a plan agreed to by the employer and employee. The work goal to which the employee should return must have demands that exceed the claimant's current validated abilities. (10) *Drug problems:* There should be documentation that the claimant's medication regimen will not prohibit them from returning to work (either at their previous job or new employment). If this is the case, other treatment options may be required, for example a program focused on

	detoxification. (11) *Program documentation:* The assessment and resultant treatment should be documented and be available to the employer, insurer, and other providers. There should documentation of the proposed benefit from the program (including functional, vocational, and psychological improvements) and the plans to undertake this improvement. The assessment should indicate that the program providers are familiar with the expectations of the planned job, including skills necessary. Evidence of this may include site visitation, videotapes or functional job descriptions. (12) *Further mental health evaluation:* Based on the initial screening, further evaluation by a mental health professional may be recommended. The results of this evaluation may suggest that treatment options other than these approaches may be required, and all screening evaluation information should be documented prior to further treatment planning. (13) *Supervision:* Supervision is recommended under a physician, chiropractor, occupational therapist, or physical therapist with the appropriate education, training and experience. This clinician should provide on-site supervision of daily activities, and participate in the initial and final evaluations. They should design the treatment plan and be in charge of changes required. They are also in charge of direction of the staff. (14) *Trial:* Treatment is not supported for longer than 1-2 weeks without evidence of patient compliance and demonstrated significant gains as documented by subjective and objective improvement in functional abilities. Outcomes should be presented that reflect the goals proposed upon entry, including those specifically addressing deficits identified in the screening procedure. A summary of the patient's physical and functional activities performed in the program should be included as an assessment of progress. (15) *Concurrently working:* The patient who has been released to work with specific restrictions may participate in the program while concurrently working in a restricted capacity, but the total number of daily hours should not exceed 8 per day while in treatment. (16) *Conferences:* There should be evidence of routine staff conferencing regarding progress and plans for discharge. Daily treatment activity and response should be documented. (17) *Voc rehab:* Vocational consultation should be available if this is indicated as a significant barrier. This would be required if the patient has no job to return to. (18) *Post-injury cap:* The worker must be no more than 2 years past date of injury. Workers that have not returned to work by two-years post injury generally do not improve from intensive work hardening programs. If the worker is greater than one-year post injury a comprehensive multidisciplinary program may be warranted if there is clinical suggestion of psychological barrier to recovery (but these more complex programs may also be justified as early as 8-12 weeks, see Chronic pain programs). (19) *Program timelines:* These approaches are highly variable in intensity, frequency and duration. APTA, AOTA and utilization guidelines for individual jurisdictions may be inconsistent. In general, the recommendations for use of such programs will fall within the following

	ranges: These approaches are necessarily intensive with highly variable treatment days ranging from 4-8 hours with treatment ranging from 3-5 visits per week. The entirety of this treatment should not exceed 20 full-day visits over 4 weeks, or no more than 160 hours (allowing for part-day sessions if required by part-time work, etc., over a longer number of weeks). A reassessment after 1-2 weeks should be made to determine whether completion of the chosen approach is appropriate, or whether treatment of greater intensity is required. (20) *Discharge documentation:* At the time of discharge the referral source and other predetermined entities should be notified. This may include the employer and the insurer. There should be evidence documented of the clinical and functional status, recommendations for return to work, and recommendations for follow-up services. Patient attendance and progress should be documented including the reason(s) for termination including successful program completion or failure. This would include noncompliance, declining further services, or limited potential to benefit. There should also be documentation if the patient is unable to participate due to underlying medical conditions including substance dependence. (21) *Repetition:* Upon completion of a rehabilitation program (e.g., work conditioning, work hardening, outpatient medical rehabilitation, or chronic pain/functional restoration program) neither re-enrollment in nor repetition of the same or similar rehabilitation program is medically warranted for the same condition or injury. **ODG Work Conditioning (WC) Physical Therapy Guidelines** WC amounts to an additional series of intensive physical therapy (PT) visits required beyond a normal course of PT, primarily for exercise training/supervision (and would be contraindicated if there are already significant psychosocial, drug or attitudinal barriers to recovery not addressed by these programs). See also Physical therapy for general PT guidelines. WC visits will typically be more intensive than regular PT visits, lasting 2 or 3 times as long. And, as with all physical therapy programs, Work Conditioning participation does not preclude concurrently being at work. Suggested Timelines: 10 visits over 4 weeks, equivalent to up to 30 hours.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**